

Referral Authorization Form (RAF)



Referring Clinician Affiliation (check one)	Information about Patient
Primary Care <input type="checkbox"/> San Mateo Coastside Clinic NPI: 1720261464 <input type="checkbox"/> Willow Clinic NPI: 1336239052 <input type="checkbox"/> Daly City Clinic NPI: 1255400909 <input type="checkbox"/> San Mateo Medical Center ___ INPT ___ OP ___ ER <input type="checkbox"/> Fair Oaks Clinic NPI: 1871529073 <input type="checkbox"/> Ravenswood / Belle Haven NPI: 1821170044 <input type="checkbox"/> South San Francisco Clinic NPI: 1609812148	Specialty <input type="checkbox"/> Innovative Care 39th Avenue Clinic ID#: GR0028880 <input type="checkbox"/> Specialty Clinic _____ <input type="checkbox"/> Ron Robinson
Patient Name: _____	
SMMC Patient Medical Record Number: _____	
SMMC Patient Account Number: _____	

Outside Provider Information	Patient Information
Provider / Vendor / Specialist: _____ NPI Number(s): _____ Address: _____ Phone Number: _____ Fax Number: _____	Address: _____ Phone Number: _____ Date of Birth: _____ HPSM / ACE Participant ID #: _____

Physician Request

Diagnosis: _____ ICD-9 Code(s) (Mandatory): _____

Reason for Outside Referral: (Attach clinical information) _____

Treatment or Service Requested: _____

Type of Referral (check one):
 Consultation only
 Consult and Treat
 Other services or supplies:

Phone Number: _____ Requesting Physician Name: _____

Fax Number: _____ Signature: _____ Date: _____

Note: Please forward consultation notes under separate cover to referral providers.

Instructions	
For Referring Provider 1) Please complete this form, and fax it to the Health Plan of San Mateo (HPSM) at 650-829-2079. URGENT FAX: 650-829-2021. 2) Incomplete or illegible forms will be returned. 3) Once the referral is approved, give a copy of this form to the patient to make an appointment with the Specialty or Out of Network Provider. 4) For questions on this request, please call HPSM Health Services at 650-616-2070.	For Provider of Service / Referral Provider 1) HPSM is contracted to process authorizations and claims on behalf of San Mateo Medical Center (SMMC). Final payment will be issued by SMMC. 2) This RAF is only valid for 90 days from receipt at HPSM for initial consult. 3) If you believe additional services are required, please contact the referring provider to develop a treatment plan. The referring provider must submit a new referral request to HPSM for the additional services to be covered. 4) Some services require prior authorization. Contact HPSM for more information on submitting a Treatment Authorization Request at 650-616-2070. 5) Authorization does not guarantee payment. Payment is subject to patient's eligibility. Be sure the ID card is current before rendering service. 6) Submit claim within 30 days to: Health Plan of San Mateo, 701 Gateway Blvd., Suite 400, South San Francisco, CA 94080.

Authorization Information

Authorized Dates of Service: _____ Authorization Number: _____

Comments: _____

Signature: _____ Date: _____

Outside provider acceptance of the referral and provision of services thereof constitutes agreement to all San Mateo County terms and provisions of payment. Moreover, by acceptance of this referral, outside provider agrees to hold harmless and indemnify San Mateo County for all losses, claims, damages, injuries, illnesses, or death to patient due to the negligence of outside provider. Reimbursement for payment made will be expected if patient is granted Medi-Cal retroactively within 30 days of notification to outside provider.

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